and the location has been in most of them the lesser curvature, pyloric end and anterior surface of the stomach.

Regarding the diagnosis of perforation of the duodenum and stomach, I have frequently said on other occasions, and to me it seems of such great importance that I venture to repeat it here. As pointed out by Bishop some years ago a sudden and very severe pain in the abdomen, perhaps producing collapse, and usually vomiting, is common to a comparatively small class of cases, such are:

1. Ruptured ectopic.
2. Ruptured pyosalpinx.
3. Ruptured appendix abscess (into the general peritoneal cavity).
4. Ruptured gastric ulcer.
5. Ruptured duodenal ulcer.
6. Ruptured gall-bladder.

Perhaps everyone present has seen an example of these ruptures and some have seen all of them. It is worthy of note that these are all ruptures of important organs throwing suddenly an irritating fluid into a healthy peritoneal cavity. Now we commence to narrow down our diagnosis by exclusion. If your patient be a male the first two conditions are excluded at once. If not, a careful history of the case will soon exclude them. Abscess of the appendix will have laid the patient up for some days previously and will have presented the usual symptoms. And so on until we have only perforation of gastric and duodenal ulcers left.

Early diagnosis is very important. Cases operated on within 12 hours usually recover. After the first 24 hours about 75 per cent. will die. The initial pain is never absent, but it may be less severe if the perforation be very small. The pain often radiates into the back and towards the left shoulder and arm just as pain in hepatic colic does to the right shoulder. We have rigidity of the upper abdomen at first, but soon extending all over the abdomen. The patient has an anxious expression, may have cold perspiration with weak slow pulse at first; indeed, at first the pulse may be hardly altered in frequency or volume. The extremities and general skin surface is cold and clammy. The patient usually assumes some fixed posture—generally bent forward. This posture is in striking contrast to the flopping around the bed of the one suffering from an attack or renal or hepatic colic. This fixed position of the patient is at times so marked that it is with great difficulty we get the body straightened out sufficiently to make an examinaion of the abdomen. However, I recall one of my patients with a perfor-